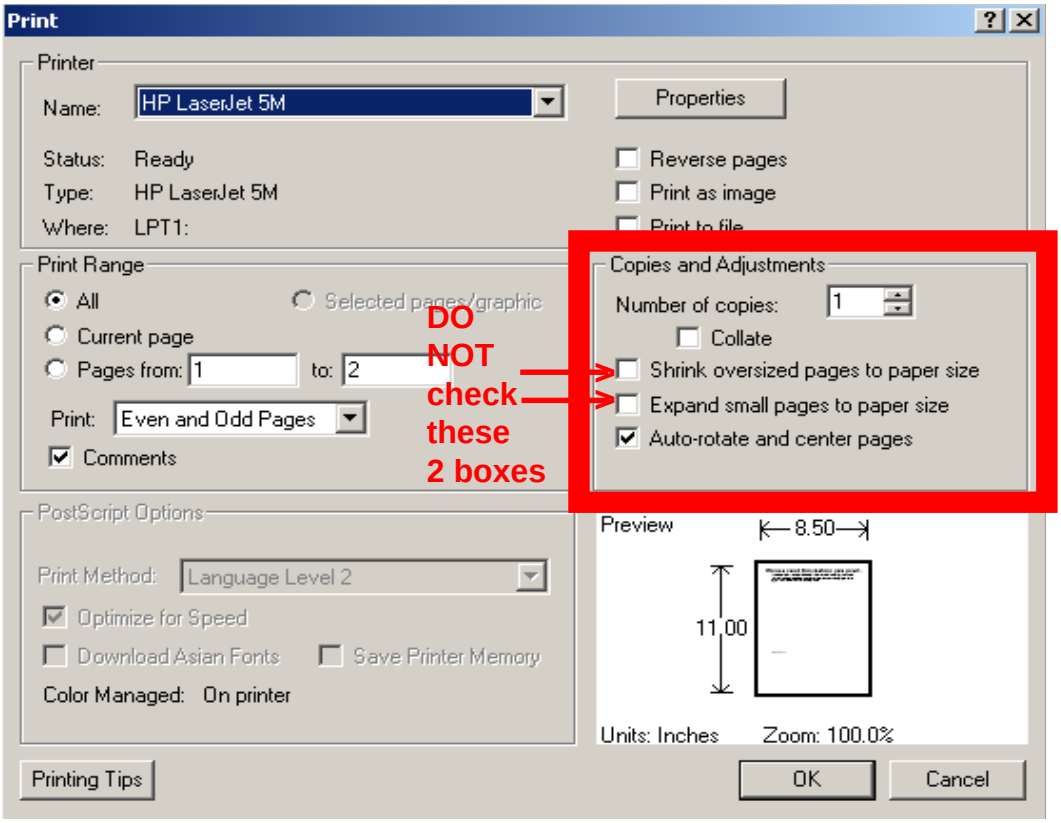
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Osteopathic Physician Assistant Application Packet

1. 663-034 .. Contents List/SSN Information/Deposit Slip ..... 1 page
2. 663-031 .. Application for License to Practice as an: ..... 4 pages
   - Osteopathic Certified Physician Assistant
   - Osteopathic Noncertified Physician Assistant
   - Osteopathic Acupuncture Physician Assistant
3. 663-041 .. Application Instructions for Licensure of Osteopathic Physician Assistant ..... 4 pages
4. 663-042 .. Approved Osteopathic Physician Assistant Programs ..... 3 pages
5. 663-043 .. Osteopathic Physician Assistant Practice Plan ..... 1 page
6. 663-044 .. Osteopathic Physician Assistant Utilization and Supervision ..... 5 pages
7. 663-045 .. Independent Prescriptive Authority Request ..... 1 page
8. 663-046 .. Physician Assistant Standardized Procedures Reference and Guidelines ..... 3 pages
9. 663-047 .. Hospital Investigative Letter ..... 1 page
10. 663-048 .. State Licensure Investigative Letter ..... 1 page

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.

* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Osteopathic Physician Assistant DEPOSIT SLIP

DOH 663-034 (REV 6/2004)

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

1A 0252120000 00488

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Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
LICENSE NUMBER	DATE

LICENSE #

Application For License To Practice as An Osteopathic Certified Physician Assistant Osteopathic Noncertified Physician Assistant Osteopathic Acupuncture Physician Assistant

Application for (check one):
- ☐ Osteopathic Certified Physician Assistant
- ☐ Osteopathic Noncertified Physician Assistant (Interim Permit)
- ☐ Osteopathic Acupuncture Physician Assistant

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Supporting documents should be filed with the Health Professions Quality Assurance Division at least sixty (60) days before license is needed. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by applicable fee (fees are nonrefundable). For applicable fee, please see instructions. Mail remittance payable to Department of Health, Revenue Section.

NOTE: The mailing address you provide will be listed on your license and all correspondence from the Department will be sent to this address until you notify us of a change.

1. Demographic Information

APPLICANT'S NAME LAST | FIRST | MIDDLE INITIAL

MAILING ADDRESS

CITY | STATE | ZIP | COUNTY

BUSINESS TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS) ( )

RESIDENCE TELEPHONE ( )

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW) — —

GENDER ☐ Female ☐ Male

BIRTHDATE (MO/DAY/YR) / /

PLACE OF BIRTH (CITY/STATE)

HEIGHT | WEIGHT | EYE COLOR | HAIR COLOR

PHYSICIAN'S ASSISTANT PROGRAM | YEAR GRADUATED

PROGRAM ADDRESS | CITY | STATE

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

2. Previous Licensure

List all licenses granted with type, date, jurisdiction, and if license is current. Include all states and professions—for example: PA, RN, LPN, etc. Attach additional 8 1/2 x 11 sheets if necessary.

STATE OR OTHER	PROFESSION	CERTIFICATE YEAR	CERTIFICATE NUMBER	PERMANENT OR TEMPORARY	LICENSE RECEIVED BY EXAMINATION	LICENSE RECEIVED BY OTHER	CURRENTLY IN FORCE
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No

3. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

4. Professional Training and Experience

List in chronological order all professional education and experience including college, university, technical or professional school and practice pertaining to the profession for which you are making application. Include all periods of time from the date of graduation from physician assistant program to the present whether or not engaged in activities related to medicine. Attach additional 8 1/2 x 11 sheets if necessary.

NAME AND LOCATION OF INSTITUTE, PLACE OF PRACTICE OR OTHER	DEGREE OR CERTIFICATE AND DATE RECEIVED OR NATURE OF EXPERIENCE OR SPECIALTY	ATTENDANCE	
		FROM (mo/yr)	TO (mo/yr)

5. Hospital Privileges

List hospitals and locations where privileges have been granted within the past five (5) years. For Locum Tenens, enter only those of a 30 day or longer duration. Attach additional 8 1/2 x 11 sheets if necessary.

NAME OF HOSPITAL AND LOCATION	DATES	
	FROM (mo/yr)	TO (mo/yr)

6. AIDS Education and Training Attestation

I certify I have completed the minimum of 7 hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

7. Applicant's Attestation

I, _____ , certify that I am the person described and identified
NAME OF APPLICANT

in this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____
SIGNATURE OF APPLICANT DATE

Official Use Only

Washington State Records Center

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Application Instructions for Licensure
Osteopathic Physician Assistant

To qualify for licensure as an osteopathic physician assistant, one must have graduated from a program approved by the Board of Osteopathic Medicine and Surgery. A list of approved programs is included in this packet. Programs must submit verification of accreditation by the Accreditation Review Commission on Education for the Physician Assistant with the Board for approval. If your program has not been approved, please contact the Board's office.

Original Applicants For Licensure Must Submit:

1. Completed Washington Osteopathic Physician Assistant application form.

   "Yes" responses to any of the questions in the Personal Data section of the application must be accompanied by documentation as stated on the application form and a brief explanation regarding your particular circumstance.

2. Licensure application fee $250. An application will not be processed without a fee. Fees are not refundable.
3. Transcripts sent directly from the applicant's P.A. program.
4. Signed affidavit indicating completion of seven hours of AIDS education.
5. Verification letters sent directly to us from all hospitals where applicant has been granted privileges for the past five (5) years.
6. Verification letters sent directly from all states in which you have ever obtained a health care license (for example: PA, RN, LPN, etc.).

   (Some states require a fee for processing verification letters. Please check with each state to determine this fee.)

7. If the applicant has previously worked as a Physician Assistant, a letter of evaluation is required from the previous sponsor.
8. Within one year of completion of an accredited training program, successfully take and pass the National Commission on Certification of Physician Assistants. Verification of certification will be completed by the Board office directly from that organization. An interim permit may be granted for one year until certification has been verified, provided the applicant meets all other requirements. The interim permit fee is $167. An $83 fee is due when certification is complete and full license is being requested.
9. A practice plan must be completed and approved prior to beginning practice. A license may be renewed and kept current without an approved practice plan with an osteopathic physician supervisor, but the physician assistant may not practice.

Practice Plan Application

1. Completed Washington Osteopathic Physician Assistant application form or have a current osteopathic physician assistant license.

   "Yes" responses to any of the questions in the Personal Data section of the application must be accompanied by documentation as stated on the application form and a brief explanation regarding your particular circumstances.

2. Practice Plan application fee of $70.00
3. Completed practice plan
4. If transferring to another osteopathic physician supervisor, verification letters sent directly from all hospitals where the applicant has been granted privileges for the past working relationship.
5. Letter of evaluation from previous supervising physician.

Prescriptive Authority

An osteopathic physician assistant may issue written or oral prescriptions as provided in WAC 246-854-030 when approved by the Board and assigned by the supervising physician. Prescriptions for legend drugs and controlled substances must each be approved or signed by the physician prior to administration, dispensing or release of the medication to the patient.

To qualify for independent prescriptive authority, the applicant must have a certificate from the National Commission on Certification of Physician Assistants, inc.

Applicants for independent prescriptive authority must submit:

1. Statement signed by the supervising physician that he or she assumes full responsibility and that he or she will review the physician assistant's prescription writing practice on an ongoing basis.
2. Description of the physician assistant's writing experience and ability.
3. Statement demonstrating the necessity in the practice for the physician assistant to be granted independent prescriptive authority.

   The sponsoring physician may complete the enclosed form for independent prescriptive authority to meet the above requirements.

4. Verification of certification sent directly from the National Commission on Certification of Physician Assistants, Inc. will be obtained by Board staff.

If an applicant has had a name change or documents were issued in a name other than the one currently being used, please indicate those names when submitting the application file.

Applications should be filed, complete with all supporting documents, at least 30 days before the license is needed. After initial review, additional documentation or information may be requested by the board. The Board of Osteopathic Medicine and Surgery may

conduct a background investigation on any applicant if documents raise questions relative to unprofessional conduct, incompetence or impairment. Applicants are advised that this process may take additional time to complete.

When all required documentation has been received, applications will be reviewed for approval.

Note: All documents must be originals. Copies or faxed documents will not be accepted.

It is the supervising physician's responsibility to assure that the best interests of the patients are served by utilizing a physician assistant, and that adequate supervision and review of the physician assistant's work is provided. Only those tasks authorized by the Board may be performed by the physician assistant.

In temporary absence of the supervising physician, the physician assistant may carry out those tasks for which they are licensed, if the supervisory and review mechanisms are provided by a delegated alternate physician supervisor or physician group. The physician assistant may not function as such if these supervisory and review functions are unavailable.

An M.D. may be the alternate supervisor for a physician assistant licensed under the Board of Osteopathic Medicine and Surgery.

The physician assistant may not advertise or mislead the public to his or her role and must wear identifying badges in a prominent place when meeting or treating patients. WAC 246-854-090(8)(a) and (b)

Following termination of supervision, the Board requires the supervising physician to submit a written report including the reasons for termination of the relationship and an evaluation of the physician assistant's performance.

Licenses are renewed on the licensee's birthday each year by paying a renewal fee. Failure to renew shall render license invalid. Fifty hours of continuing medical education will be required for renewal annually. Please keep the Board office advised of any address changes so that you will receive your renewal notice.

The current residential address and telephone number of healthcare provider governed under Chapter 18.130 RCW is not releasable as public information.

The application process is considered confidential. Information about a pending application will only be provided to: 1) the applicant, (communications relative to osteopathic physician assistant practice plans may be made with the sponsor or alternate physician and the physician assistant, or 2) a designated representative identified and granted approval in writing by the applicant.

For additional information you may contact our office at (360) 236-4943.

Send all supporting documents to:

Licensing Representative
Board of Osteopathic Medicine and Surgery
PO Box 47869
Olympia, Washington 98504-7869
(360) 236-4943

Send application and fee to:

Licensing Representative
Board of Osteopathic Medicine and Surgery
PO Box 1099
Olympia, Washington 98507-1099
(360) 236-4943

Renewal information and Osteopathic Physician Assistant Application Packets:

Customer Service Center
(360) 236-4700
Email: hpqacsc@doh.wa.gov

Washington State Department of Health

Approved Osteopathic Physician Assistant Programs

University of Washington ..... Approved
Medex Northwest
Seattle, Washington

University of Washington ..... NOT APPROVED
Correctional Health Specialist 1-24-92

Gynecorps Training Program ..... Approved 4-12-77
OB/GYN
Seattle, Washington

Cuyahoga Community College ..... Approved 1-11-77
Physician's Assistant Program
Parma, Ohio

University of Utah ..... Approved
MEDEX
50 North Medical Drive
Salt Lake City, UT 84112

Case Western Reserve ..... Approved 4-11-78
7th Floor Lakeside
2065 Adelbert Road
Cleveland, Ohio 44106

Charles R. Drew Postgraduate ..... Approved 7-11-78
Medical School & UCLA School of Medicine
MEDEX Physician's Assistant Training Program
1621 East 120th Street
Los Angeles, California 90059

Kettering College of Medical Arts ..... Approved 10-10-78
3737 South Boulevard
Dayton, Ohio

Academy of Health Sciences, US Army ... Approved 1-9-79
Department of the Army
Fort Sam Houston, Texas

University of Nebraska Medical Center ... Approved 4-10-79
Physician's Assistant Program
42 Street and Dewey Avenue
Omaha, Nebraska

George Washington University ..... Approved 7-31-79
Medical Center
Physician's Assistant Program
1331 H Street, NW
Washington, D.C. 20037

University of North Dakota ..... Approved 5-30-80
Family Nurse Practitioner Program
221 South 4th Street
Grand Forks, North Dakota 58201

University of Iowa ..... Approved 1-22-81
Physician's Assistant Program
Iowa City, Iowa 52242

Los Angeles Co., Harbor
General Hospital ..... Approved 10-15-82
Women's Health Care Specialist
Torrence, California
(Program discontinued 1978)

Gallup Indian Medical Center ..... Approved 10-15-82
Community Health Medic Training Program
Gallup, New Mexico

Duke University ..... Approved 7-15-83
Physician's Associate Program
Durham, North Carolina

Western Michigan University ..... Approved 11-13-87
College of Health & Human Services
Kalamazoo, Michigan 49008-5138

University of Wisconsin ..... Approved 3-88
Madison Medical School
1050 Medical Sciences Center
1300 University Avenue
Madison, WI 53706

Medical College of Georgia ..... Approved 10-14-88
BD #328
Augusta, Georgia 30912

Medical University of South Carolina ..... Approved 11-18-88
171 Ashley Avenue
Charleston, South Carolina 29425-2970

Alderson Broaddus College ..... Approved 11-3-89
Physician Assistant Program
PO Box 578
Philippi, WV 26416

University of Oklahoma at
Oklahoma City ..... Approved 11-3-89
Physician Assistant Program
PO Box 26901
Oklahoma City, OK 73190

Wichita State University ..... Approved 11-3-89
Physician Assistant Program
1845 N. Fairmont
Wichita, KS 67208

University of Osteopathic Medicine ..... Approved 1-19-90
and Health Sciences
Physician Assistant Program
3200 Grand Avenue
Des Moines, IA 50312

Baylor College of Medicine ..... Approved 9-28-90
One Baylor Plaza
Houston, TX 77030

Trevecca Nazarene College ..... Approved 1-18-91
333 Murfreesboro Road
Nashville, TN 37210-2877

University of Detroit Mercy ..... Approved 1-24-92
8200 West Outer Drive
Detroit, Michigan 48219-3599

St. Louis University ..... Approved 1-24-92
1504 South Grand Boulevard
St. Louis, MO 63104

College of Osteopathic Medicine ..... Approved 7-10-92
of the Pacific
College Plaza
Pomona, CA 91766-1889

The University of Texas School ..... Approved 10-2-92
of Allied Health Sciences at
Galveston, Texas
The University of Texas
Medical Branch
Galveston, TX 77550

University of Alabama ..... Approved 6-24-94
University Station
Birmingham, Alabama 35294
CAHEA APPROVED June 1973 through August 1976

University of Kentucky ..... Approved 1-20-95
Department of Health Services
Physician Assistant Program
Medical Center Annex 2, Room 113
Lexington, Kentucky 40536-0080

Touro College ..... Approved 11-3-95
Physician Assistant Program
135 Carmen Road, Building #14
Dix Hills, New York 11746-5652

Northeastern University ..... Approved 11-3-95
Physician Assistant Program
202 Robinson Hall
Boston, Massachusetts 02115

Hahnemann University ..... Approved 1-31-97
Allegheny University of the Health Sciences
Broad & Vine
Philadelphia, Pennsylvania 19102-1192

Nova Southeastern University ..... Approved 8-5-97
3301 College Avenue
Ft. Lauderdale, Florida 33314

Oregon Health Services University ..... Approved 10-30-97
3181 SW Sam Jackson Park Road
Portland, Oregon 97201-3098

Kings College ..... Approved 12-5-97
133 North River Street
Wilkes Barre, Pennsylvania 18711

Midwestern University ..... Approved 7-22-98
555–31st Street
Downers Grove, Illinois 60515
(630) 969-4400

Marshfield ..... Approved 7-22-98
1000 N. Oak Avenue
Marshfield, Wisconsin 54449-5777
(715) 387-5580

Yale University School of Medicine ..... Approved 10-14-98
Physician Associate Program
47 College St., Suite 220
New Haven, CT 06501
(203) 785-4252

D'Youville College ..... Approved 11-20-98
One D'Youville Square
320 Porter Ave.
Buffalo, NY 14201-1084

Finch University of Health Sciences/ ..... Approved 6-2-2000
The Chicago Medical School
Physician Assistant Dept.
School of Related Health Sciences
3333 Green Bay Rd.
North Chicago, IL 60064-3095
(847) 578-3312

College of Health Sciences ..... Approved 8-2-2000
Physician Assistant Program
920 S. Jefferson Street
PO Box 13186
Roanoke, VA 24031-3186
(540) 985-8483 or toll-free (888) 985-8483

University of Colorado Health
Sciences Center ..... Approved 1-26-2001
CHA / PA Program
4200 E. 9th Ave., C219
Denver, CO 80262
(303) 315-7963 FAX (303) 315-6976

Medical College of Ohio ..... Approved 1-26-2001
School of Allied Health
Dept. of PA Studies
Howard L. Collier Building
3015 Arlington Ave.
Toledo, OH 43614-5803
(419) 383-5408 FAX (419) 383-5880

University of California, Davis ..... Approved 6-1-2001
FNP/Physician Assistant Program
2516 Stockton Blvd., #254
Sacramento, CA 95817
(916) 734-3551

Stanford University / Foothill College ..... Approved 6-1-2001
Primary Care Associate Program
703 Welch Road, Suite F1
Palo Alto, CA 94304-5750
(650) 723-7043 or (650) 725-4487

Albany-Hudson Valley-C, A ..... Approved 1-18-2002
Physician Assistant Program
Albany Medical College
47 New Scotland Ave., Mail Code 4
Albany, NY 12208
(518) 262-5251

Lake Erie College ..... Approved 8-9-2002
Physician Assistant Program
Painesville, Ohio
(Accredited Mach 1977;
Program Closed July 1987)

Pacific University—Oregon ..... Approved 9-13-2002
School of Physician Studies
2043 College Way
Forest Grove, OR 97116
(503) 352-2898

Union College ..... Approved 1-31-03
Physician Assistant Program
3800 South 48th Street
Lincoln, NE 68506-4386
(402) 486-2527

Arizona School of Health Sciences ..... Approved 10-10-03
(Division of Kirksville College of
Osteopathic Medicine)
Physician Assistant Program
5850 East Still Circle
Mesa, AZ 85206
(602) 841-4077

University of Medicine and Dentistry
of New Jersey ..... Approved 4-2-04
Physician Assistant Program
675 Hoes Lane
Piscataway, NJ 08854-5635
(732) 235-4444
Fax (732) 235-4820
www2.umdnj.edu/paweb

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Washington State Department of Health

Osteopathic Physician Assistant Practice Plan

NAME OF P.A.		LICENSE NO.
BUSINESS ADDRESS		
CITY	STATE	ZIP
TELEPHONE NO.		COUNTY

Supervising Physician

PHYSICIAN NAME		LICENSE NO.
BUSINESS ADDRESS		
CITY	STATE	ZIP
TELEPHONE NO.		COUNTY

Alternate Supervisor

PHYSICIAN NAME		LICENSE NO.
BUSINESS ADDRESS		
CITY	STATE	ZIP

Physician Group

NAME OF THE GROUP		LICENSE NO.
BUSINESS ADDRESS		
CITY	STATE	ZIP

If alternate supervision is being provided by a physician group, outline how supervisory responsibility will be accomplished in the absence of the assigned supervisory osteopathic physician.

LAST SUPERVISING PHYSICIAN_____

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Osteopathic Physician Assistant Utilization and Supervision

Practice Settings—Complete only those sections applicable to your practice.

Office Practice Setting (Includes HMO): Provide a brief summary of the general duties to be performed by the physician assistant in the office setting.

Hospital Practice (Note that all duties listed in this section may be approved by the Board, but it is at the discretion of the hospital to allow them under its bylaws.)

☐ Yes, the P.A. will practice in the following hospitals: (List names and cities)

NAME OF HOSPITAL	CITY

Provide a brief summary of the general duties to be performed by the physician assistant in the hospital setting.

In addition to the general duties, the physician assistant will perform the following in the hospital setting: (Check only those you wish approved.)

☐ Writing orders in hospital charts which are by:

- ☐ Physician written standing orders
- ☐ Physician verbal orders (indicated as such in the chart by P.A. signature and designation of who provided verbal order.)
- ☐ Physician assistant determination of need with follow-up by physician who co-signs within period of time designated by hospital.

These orders will include:

- ☐ Treatment plan
- ☐ Lab tests and X-rays
- ☐ Medications
- ☐ Other _____

☐ Assisting in surgery:

- ☐ 1st assisting
- ☐ 2nd assisting

☐ P.A. will be assisting in the following surgical procedures:

- ☐ Major surgical procedures
- ☐ Minor surgical procedures
- ☐ Emergency Room—The P.A. will take a call in the hospital emergency room.

Describe how ER call will be arranged and how supervision will be carried out and maintained.

Nursing Home Practice (Note that all duties listed in this section may be approved by the Board, but it is at the discretion of the nursing home to allow them to be performed in its facility.)

NAME OF NURSING HOME	CITY

☐ Yes, the P.A. will practice in the following nursing home(s). (List names and cities.)

Provide a brief summary of the general duties to be performed by the physician assistant in the nursing home setting and how supervision will be accomplished.

Other Practice Areas: List in this section any other areas the physician assistant will practice in (such as home health care, special clinics, schools, institutions, or special education clinics, etc.) Provide a brief summary of the general duties to be performed by the P.A. in each setting.

Indicate practice sites and percentage of time spent at each for both the P.A. and supervising physician.		
Practice Sites	**% of Time for P.A.**	**% of Time for D.O.**
Clinic		
Hospital		
Institution		
Remote Site		
HMO		
Nursing Home		
Emergency Room		
Other_____		

NOTE: Percentage of time should equal 100%.

Supervision (Check those applicable to the P.A. practice)

☐ A. My physician assistant will be in my regular city and area of practice and will be supervised by me as described below. I or the alternate supervisor(s) will be available for direct on-site or telephone consultation and supervision at all times when my physician assistant is on duty.

☐ B. My physician assistant will be practicing in a remote site which is separate from my regular practice, and I will provide supervision by telephone, periodic visits, and other means of communication. (Explain in detail in the Remote-Site section.) The practice will be a full time practice for the physician assistant.

☐ C. My physician assistant will be practicing part-time in a remote site. (Explain in detail in the Remote-Site section.) (check one)

- ☐ This is not my regular city/area of practice.
- ☐ This is my regular city/area of practice, but I will not be present for planned periods of time. For the part time remote practice supervision will be provided as explained in the Remote Site section. The remainder of the practice will be supervised as explained in A. and will be in the same city or in _____ (list site).

☐ D. Periods of Absence/Vacation (check one)—This section applies to both remote and direct supervision practices. When I am away from the office or practice location for any period of time, including vacation, continuing education, or illness:

- ☐ A designated alternate supervisor(s)/physicians group will supervise my physician assistant at all times in accordance with the practice description.
- ☐ My physician assistant will cease to function as such, as I have not designated any alternate supervising mechanism for my physician assistant.

☐ E. Chart Review—Every written entry shall be reviewed, countersigned and dated by me or the designated alternate(s) within _____ working days.

☐ F. EKG's, x-rays, laboratory tests and special studies shall be reviewed within 24 hours.

How many physician health care providers do you supervise? _____

Number of P.A.'s _____ OTHER (Specify Job Titles) _____

Explain Level of Supervision required for other health care providers supervised.

Approximate number of patients to be seen weekly by P.A.? _____

If the alternate supervisor(s)/physician group are not located in the same office, where is his/her practice in relation to the P.A.'s setting(s)?

Remote Site Section (If the physician assistant is to be in a remote site, complete the following).

NAME OF REMOTE SITE		
ADDRESS OF REMOTE SITE		
CITY	STATE	ZIP CODE
PHONE NUMBER		

Supply a detailed plan for supervision and chart review.

Include an explanation of the community need for utilization of a physician assistant in the remote site. (Please see WAC 246-854-090 Osteopathic Physicians Assistants Utilization.)

Provide explanation for establishing patient/osteopathic physician relationship for patients with ongoing medical needs.

We hereby certify under penalty of perjury under the laws of the State of Washington that the foregoing information in this practice plan is correct to the best of our knowledge and belief. We further certify we have reviewed the current rules and regulations of the Board of Osteopathic Medicine and Surgery pertaining to osteopathic physician assistants and this practice description and understand our roles and responsibilities.

Signature of Physician Assistant

Date

Signature of Supervising Physician

Date

Signature of Alternate Physician
(only if single alternate is indicated)

Date

Retain a copy of this Utilization Form as reference and guide for review by a Department of Health representative in the event of a site-review visit.

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Washington State Department of Health

Independent Prescriptive Authority Request

Authority to issue prescriptions without the prior approval or signature of the supervising physician may be granted by the Board to an osteopathic physician's assistant. Please complete the following:

Statement demonstrating the necessity in the practice for the physician assistant to be granted independent prescriptive authority.

Description of physician assistant's prescriptive writing experience and pharmacology knowledge.

Responsibility Statement.

I agree to assume full responsibility for supervision of the medical practice and prescriptive writing relative to

I also agree that appropriate inter-professional consultations will occur routinely.

SIGNATURE, SUPERVISING PHYSICIAN

In addition to the above, verification of passing the National Commission on Certification of Physician Assistants' certification examination will be obtained by Board staff.

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Washington State Department of Health
Board of Osteopathic Medicine and Surgery
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4943

Physician Assistant Standardized Procedures Reference and Guidelines

The following is a list of Board approved procedures for physician assistants. Physician assistants may provide those services that they are competent to perform based on their education, training, and experience. The supervising physician(s) and the physician assistant shall determine which procedures may be performed and the degree of supervision to which the physician assistant performs the procedure within the Board's recommended guidelines.

1. The procedure is performed under the general supervision and control of the supervising or alternate physician but does not necessarily require the personal presence of the supervising/ alternate physician at the place where services are rendered.
2. The procedure is performed with the knowledge and concurrence of the supervising/alternate physician. The supervising/alternate physician must be present in the facility at the time the services are being rendered.
3. The physician assistant may directly assist the supervising/alternate physician with the procedure.

Board approval of hospital procedures are dependent upon approval by individual hospitals. Hospital by-laws and policies may not be consistent with board recommended procedures.

A physician assistant may request permission to perform a specific procedure to a greater degree than indicated by the Board. Indicate to what degree of supervision the procedure would be performed, provide an explanation of the reasons for the request, and the physician assistant's qualifications relative to performing that procedure. This criteria would also apply to any procedures not listed.

Hospital Procedures

Admit Patients 1
Emergency Room 1
History 1
PE 1
Admitting Diagnosis 1
Treatment 1
Emergency Room 1
Charting 1
Write Orders 1
Make Rounds 1
Write Discharge Summaries 1
Paracentesis 3
Chest Tubes 3
Foley Catheters 1
Arterial Lines 3
Swanz-Ganz Catheter 3
CVP 3
Order Blood Products 1
Order IV's 1
Change Dressings 1
Emergency Room Call with 1
supervising physician in 1
hospital/backup 1
X-rays 1
Order x-rays 1
Take x-rays 1
a. Routine 1
b. Special Procedures 1
Specify _____ 1
Other (specify) _____

Surgery

Suturing 1
Remove Sutures 1
Operating Room 1
Minor Surgery
1st Assistant 1
2nd Assistant 1
Major Surgery
1st Assistant 1
2nd Assistant 1
Pre-Op HX 1
Pre-Op PX 1
Post-Op Care 1
Dressing Changes 1
ICU Care 2
Sterilize Instruments 1
Set Up Trays 1
Prep Patients 1
Closure 1
Circumcisions (new born only) 2
Remove skin lesions 2
Biopsies 2
Other (specify) _____

Nursing Home Procedures

History 1
PE 1
Diagnosis 1
Treatment 1
Emergency Call 1
IV's 1
EKG's 1
Other (specify) _____

Office Procedures

Drawing Blood 1
Injections 1
IV Meds 1
Joint Injections or Taps 2
Diagnosis 1
Remove Cysts 2
Biopsies 2
Removing Lesions 2
Remove Warts 1
Ingrown Toenails 1
Cauterize Warts 1
I & D of Abscess 1
Fluorescein Stain Eyes 1
Pack Nose Bleeds 1
Wax Removal—Ears 1
Remove F.B.'s from Nose 1
Remove F.G.'s from Ears 1
Pierce Ears 1
Tonometry 1
Suturing Lacerations (uncomplicated) 1
Change Dressings 1
Take EKG's 1
Screen EKG's for abnormalities 1
Exercises Testing 2
Pulmonary Function Tests 1
Sigmoidoscopy 2
Remove Thrombosed Hemorrhoids 2
Prep for Cystoscopy 1
Care of Cystoscopic Instruments 1
Urethral Dilatation 2
Urine Catheterization 1
Bladder Taps 2
Diathermy—Ultrasound 1
Spinal Taps 3
Take x-rays 1
Order x-rays 1
Screen x-rays for abnormalities 1
Office Management 1
Maintain and Order Supplies 1
Other (specify) _____

Orthopedics

HX (Ortho) 1
PE (Ortho) 1
DX (Ortho) 1
Casting Non-displaced Fractures 1
Casting Sprains 1
Casting Displaced fractures
after reduction 2
Reducing Fractures 2
Reducing Dislocated Shoulders 2
Reducing Dislocated Fingers/Toes 1
Removing Casts 1
Application of Traction
Mechanisms 2
Spicas 2
Removal of Pins 2
Brace Fitting 2
Physical Therapy 1
Other (specify) _____

Exams

Complete Physical 1
Acute 1
Chronic 1
Emergency 1
Limited Physical 1
Other (specify) _____

Emergency

H X 1
PE 1
Diagnosis 1
Treatment and Plan 1
Cardioversion 1
Cardiac Resuscitation 1
Other (specify) _____
Intubation 1
IV Cut Downs 1
Poisoning 1
NG Tube 1
Burns 1
Other (specify) _____

Counseling/Patient Education

Behavior Modification 1
Sex Counseling 1
Rape Counseling 1
Social Work (housing/food) 1
Nutrition 1
Long Term Therapy 1
Crisis Intervention 1
ETOH
Referral 1
Treatment 1
Drug Abuse Counseling 1
Adolescence Counseling 1
Chronic Disease Education 1
Other (specify) _____

Lab

CBC's 1
Hematocrits 1
UA's 1
Gram Stains 1
Throat Cultures 1
Wet Mount 1

Home Health

Home Visits 1
Home Treatment 1
Other (specify) _____

OB-Gyn

Prenatal 1
Prenatal Follow-up 1
Delivery 3
Emergency Only 1
Childbirth Education 1
Birth Control 1
Insert I.U.D.'s 2
Routine Paps and Pelvics 1
Other (specify) _____

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Washington State Department of Health
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Hospital Investigative Letter

NAME OF APPLICANT (Please Print) _____ BIRTHDATE (MONTH/DAY/YEAR) _____

I have applied to the Washington State Board of Osteopathic Medicine and Surgery for a license to practice as an osteopathic physician assistant. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my hospital privileges and return it directly to:

Board of Osteopathic Medicine and Surgery
PO Box 47869
Olympia, Washington 98504-7869
(360) 236-4943

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Board of Osteopathic Medicine and Surgery.

SIGNATURE OF APPLICANT _____ DATE _____

1. Does the applicant have, or has he/she ever had admitting or specialty privileges at your hospital? ☐ Yes ☐ No

   Beginning Date _____ Ending Date _____

2. Have the applicant's privileges ever been restricted, suspended or revoked by the medical staff or administration, or has he/she ever been asked to resign? ☐ Yes ☐ No

   If so, for what reason _____

   _____

   _____

3. Is there any information in your files that could call into question the applicant's ability to safely practice medicine and surgery? ☐ Yes ☐ No

   If yes, please explain _____

Please attach any copies of information in your records that would provide further information.

Name _____

Title _____

Facility _____

Address _____

_____

Telephone Number _____

Authorized Signature _____

Date _____

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Washington State Department of Health
Board of Osteopathic Medicine and Surgery
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4943

State Licensure Investigative Letter

NAME OF APPLICANT (Please Print) _____ BIRTHDATE (MONTH/DAY/YEAR) _____

I have applied for a license to practice as an osteopathic physician assistant in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my state licensure and return it directly to:

Board of Osteopathic Medicine and Surgery
PO Box 47869
Olympia, Washington 98504-7869
(360) 236-4943

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Board of Osteopathic Medicine and Surgery.

SIGNATURE OF APPLICANT _____ DATE _____

To assist the Washington State Board in evaluating the above physician assistant's application, we would appreciate receiving the following information.

Licensed as _____

License Number _____ Date license was issued _____

Is license current? ☐ Yes ☐ No

Has the applicant's license ever been suspended or revoked, or has any other disciplinary action been taken?
☐ Yes ☐ No

If yes, for what reason? _____

Please attach copies of any disciplinary orders or any other pertinent information and documents.

Authorized Name _____

Title _____

State Board _____

State Seal

Authorized Signature _____

Date _____